BENEFIT	**CO-PAY AMOUNT** ***The maximum co-payments you will be required to pay are $1000.00 per person/per year**
Physician Services	$5 co-pay per visit
Hospital Emergency Room	$30 co-pay per visit for emergencies
Emergency Transportation by Ambulance for Medical Emergencies	No co-pay – limited to emergency transportation
Medical Equipment and Supplies	10% co-pay for covered services over $50
Pre-existing Condition Waiting Period	No Waiting Period
Pharmacy (Four prescriptions per month)	$5 co-pay for prescriptions on preferred list; 25% of the allowed amount for drugs not on preferred list
Laboratory	5% co-pay of the allowed amount if over $50
X-rays	5% co-pay of the allowed amount if over $100
Dental Services, Including, examinations, x-rays, cleanings and fillings	10% co-pay of allowed amount
Vision Screening (One Eye Exam Per Year, Prescription Eyeglasses and Contacts not Included))	$5 co-pay; one eye exam per year
General preventative services and health education	

*Note: This is a summary only and plan restrictions may apply. Please contact your plan for specific plan requirements.